CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 719

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: OCTOBER 21, 2005

Change Request 4103

SUBJECT: Clarification and Update to Hospital Billing Instructions and Payment for Epoetin Alfa (EPO) and Darbepoetin Alfa (Aranesp) for Beneficiaries with End Stage Renal Disease (ESRD)

I. SUMMARY OF CHANGES: Effective January 1, 2006 the definition of value code 49 is changed to report the most recent hematocrit reading taken before the start of the billing period. Since it is not expected that hospitals will have a reading before the start of their billing period, hospitals will no longer be required to report the value code 49 when submitting claims for EPO or Aranesp. The CMS Medicare Benefit Policy Manual 100-2, Chapter 6, Section 10 provides for the coverage of Epoetin Alfa under the inpatient Part B benefit. Currently, when hospitals bill for Q4055 on their inpatient Part B claims (type of bill 12x), it must be reported under the revenue code 0636. This is contrary to their billing of Q4055 on the hospital outpatient claims (type of bill 13x) that requires the use of the revenue codes 0634 and 0635. For consistency of hospital reporting of Q4055, with the implementation of this instruction, hospitals will begin using the revenue code 0634 for EPO less than 10,000 units and revenue code 0635 for EPO over 10,000 units when billing Q4055 under the inpatient Part B benefit on bill type 12x. The total number of units as a multiple of 1000 units is placed in the units field.

NEW/REVISED MATERIAL: N/A

EFFECTIVE DATE: January 1, 2006 for BRs 4103.1, and 4103.2, January 1, 2004 for BR 4103.3 and 4103.5x, April 1, 2006 for BRs 4103.4.x and 4103.6x within one week of availability of the Medlearn article.

IMPLEMENTATION DATE: April 03, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	8 / 60 / 60.4 Epoetin Alfa (EPO) For ESRD Patients
R	8 / 60 / 60.4.3 Payment Amount for Epoetin Alfa (EPO)
R	8 / 60 / 60.4.3.1 Payment for Epoetin Alfa (EPO) in Other Settings
R	8 / 60 / 60.4.3.2 Epoetin Alfa (EPO) Provided in Hospital Outpatient Departments
R	8 / 60 / 60.7.3.1 Payment for Darbepoetin Alfa (Aranesp) in Other Settings
R	8 / 60 / 60.7.3.2 Payment for Darbepoetin Alfa (Aranesp) in the Hospital Outpatient Department
N	17 / 80 / 80.9 Hospitals Billing for Epoetin Alfa (EPO) for Non-ESRD Patients
N	17 / 80 / 80.10 Hospitals Billing for Darbepoetin Alfa (Aranesp) for Non-ESRD Patients

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 719	Date: October 21, 2005	Change Request 4103

SUBJECT: Clarification and Update to Hospital Billing Instructions and Payment for Epoetin Alfa (EPO) and Darbepoetin Alfa (Aranesp) for Beneficiaries with End Stage Renal Disease (ESRD)

I. GENERAL INFORMATION

A. Background: On June 4, 2004, the Centers for Medicare and Medicaid Services issued transmittal 197, Change Request 3184 with instructions for emergency hospital outpatient billing of Epotein Alfa (EPO) and Darbepoetin Alfa (Aranesp). This instruction included the requirement of hospitals to report the HCPCS code Q4055 with revenue codes 0634 and 0635 for EPO administered to beneficiaries with ESRD in the emergency room setting. This instruction also required the reporting of value code 49 with the latest hematocrit reading taken during the current billing period for outpatient claims with Q4054 (Aranesp) and Q4055 (EPO). Since that time, the National Uniform Bill Committee (NUBC) has changed the definition of the value code 49. Effective January 1, 2006 the definition of value code 49 is changed to report the most recent hematocrit reading taken **before** the start of the billing period. Since it is not expected that hospitals will have a reading before the start of their billing period, effective January 1, 2006, hospitals will no longer be required to report the value code 49 when submitting Part B claims for EPO or Aranesp.

The CMS Medicare Benefit Policy Manual 100-2, Chapter 6, Section 10 provides for the coverage of Epoetin Alfa under the inpatient Part B benefit. Currently, when hospitals bill for Q4055 on their inpatient Part B claims (type of bill 12x), it must be reported under the revenue code 0636. This is contrary to their billing of Q4055 on the hospital outpatient claims (type of bill 13x) that requires the use of the revenue codes 0634 and 0635. For consistency of hospital reporting of Q4055, with the implementation of this instruction, hospitals will begin using the revenue code 0634 for EPO less than 10,000 units and revenue code 0635 for EPO over 10,000 units when billing Q4055 under the inpatient Part B benefit on bill type 12x. The total number of units as a multiple of 1000 units is placed in the units field.

Hospitals should continue to report Darbepoetin Alfa (Q4054) under revenue code 0636 for their outpatient and inpatient Part B claims. CMS is aware of a current problem with the inpatient Part B claims (bill type 12x) containing HCPCS code Q4054 for Aranesp. The processing of those claims will be permitted with the implementation of this instruction.

All other rules for EPO and Aranesp not mentioned in this instruction are still applicable.

B. Policy: Upon implementation of this instruction, the following changes will be applied to hospitals billing for EPO and Aranesp to beneficiaries with ESRD:

- Effective for claims with dates of service on or after January 1, 2006 hospitals are no longer required to report the value code 49 when submitting claims with Aranesp (Q4054) and EPO (Q4055).

- For hospital inpatient Part B claims (bill type 12x) billing for Q4055 with dates of service prior to April 1, 2006, submit the service using revenue code 0636. Payment is made on reasonable cost.

- Effective for claims with dates of service on or after April 1, 2006, hospitals billing for Q4055 under the inpatient Part B benefit (bill type 12x), shall report the charges under the revenue code 0634 for EPO units under 10,000 and revenue code 0635 for EPO units over 10,000. Report the total number of units as a multiple of 1000 units in the units field.

- Effective for claims with dates of service on or after April 1, 2006, hospitals billing for Q4055 under the inpatient Part B benefit (bill type 12x) will be reimbursed under the same methodology applicable to the outpatient Part B setting using the payment allowance limit for Medicare Part B drugs.

- Effective for claims with dates of service on or after January 1, 2004, hospitals billing for Q4054 under the inpatient Part B benefit (bill type 12x) will be reimbursed under the same methodology applicable to the outpatient Part B setting using the payment allowance limit for Medicare Part B drugs.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4103.1	Medicare systems shall no longer require the use of value code 49 on bill types 12x, 13x and 85x when submitted with Aranesp HCPCS Q4054 with dates of service on or after January 1, 2006.					x				
4103.2	Medicare systems shall no longer require the use of value code 49 on bill types 12x, 13x and 85x when submitted with EPO HCPCS Q4055 with dates of service on or after January 1, 2006.					x				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4103.3	Medicare contractors shall process bill type 12x with revenue code 0636 and HCPCS Q4055 for claims with dates of service prior to April 1, 2006 and pay on reasonable cost.	x								
4103.4	For claims with dates of service on or after April 1, 2006, contractors shall accept claims for EPO when billed under the inpatient Part B benefit with the following data: • Type of bill = 12x • Revenue 0634 "EPO under 10,000 units" and / or Revenue code 0635 "EPO over 10,000 units" • HCPCS Q4055: "1000 units of EPO for ESRD patient" • The units field as a multiplier to arrive at the dosage amount. • Diagnosis code 585.6	x				x				
4103.4.1	Contractors shall pay for Q4055 on bill type 12x for claims with dates of service on or after April 1, 2006, according to the payment allowance limit for Medicare Part B drugs as found in the ASP Pricing File.	x				x				
4103.4.2	Contractors shall calculate coinsurance based on the payment amount for Q4055 on the bill type 12x.	x				x				
4103.4.3	Contractors shall apply the Medicare Part B deductible to Q4055 on the bill type 12x.	x				x				
4103.5	For claims received with dates of service on or after January 1, 2004, contractors shall accept claims for Aranesp when billed under the inpatient Part B benefit with the following data: • Type of bill = 12x • Revenue 0636 "Drugs Requiring Specific Information"	x				x				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	• HCPCS Q4054: Aranesp 1 mcg • The units field as a multiplier to arrive at the dosage amount • Diagnosis code 585 or 585.6 as applicable									
4103.5.1	Contractors shall override timely filing for those 12x bills containing Q4054.	x								
4103.5.1.1	Contractors are not required to search claim history and make adjustments but should adjust claims if request by the provider.	x								
4103.5.2	Contractors shall pay for Q4054 on bill type 12x when received with dates of service on or after January 1, 2004, according to the payment allowance limit for Medicare Part B drugs as found in the ASP Pricing File.	x				x				
4103.5.3	Contractors shall calculate coinsurance based on the payment amount for Q4054 on the bill type 12x.	x				x				
4103.5.4	Contractors shall apply the Medicare Part B deductible to Q4054 on the bill type 12x.	x				x				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4103.6	Contractors shall inform hospitals billing for EPO HCPCS Q4055 on bill types 13x and 85x with dates of service between January 1, 2006 and March 31, 2006 to submit the claims on or after April 1, 2006.	x								
4103.6.1	Contractors shall inform hospitals to submit their 12x claims containing Q4054 on or after April 1, 2006. Timely filing will be bypassed for 6 months following the implementation date.	x								
4103.6.2	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	x								

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 for BRs 4103.1, and 4103.2, January 1, 2004 for BR 4103.3 and 4103.5x, April 1, 2006 for BRs 4103.4.x and 4103.6x within one week of availability of the Medlearn article. **Implementation Date:** April 3, 2006 **Pre-Implementation Contact(s):** Billing: Wendy Tucker, Wendy.Tucker@cms.hhs.gov, 410-786-3004 or Jason Kerr, Jason.Kerr@cms.hhs.gov 410-786-2123. Policy: Henry Richter 410-786-4562 **Post-Implementation Contact(s):** Appropriate RO contact.	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Claims Processing Manual

Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

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(Rev.719, 10-21-05)

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60.4 - Epoetin Alfa (EPO) *For ESRD Patients*

Note: For EPO billing instructions for Non-ESRD beneficiaries, see the Claims Processing Manual, Chapter 17.

(Rev. 719, Issued: 10-21-05, Effective: 01-01-06 BRs 4103.1 and 4103.2, 01-01-04 BRs 4103.3 and 4103.5x, 04-01-06 BRs 4103.4x and 4103.6x, Implementation: 04-03-06)

Coverage rules for EPO are explained in the Medicare Benefit Policy Manual, Chapter 11. For an explanation of Method I and Method II reimbursement for patients dialyzing at home, see §40.1.

Intermediaries pay for EPO to ESRD facilities as a separately billable drug to the composite rate. No additional payment is made to administer EPO, whether in a facility or a home. Effective January 1, 2005, the cost of supplies to administer EPO may be billed to the FI. HCPCS A4657 and Revenue Code 270 should be used to capture the charges for syringes used in the administration of EPO.

If the beneficiary obtains EPO from a supplier for self-administration, the supplier bills the DMERC and the DMERC pays at the rate shown in §60.4.3

Program payment may not be made to a physician for EPO for self-administration. Where EPO is furnished by a physician payable as, "incident to services" the carrier processes the claim.

EPO Payment Methodology

Type of provider	Separately Billable	DMERC Payment	No payment
In-facility freestanding and hospital based ESRD facility	X		
Self-administer Home Method I	X		
Self administer Home Method II		X	
Incident to physician in facility or for self-administration *			X

* Medicare pays for a drug if self-administered by a dialysis patient. When EPO is *administered in* a renal facility, the service is not an "incident to" service and not under the "incident to" provision.

The Dialysis Outcomes Quality Initiative recommends a threshold hematocrit value range of 33 to 36 percent. National policy requires FIs and carriers to identify practitioners with an atypical number of patients with hematocrit levels above a 90-day rolling average of

37.5 percent for routine medical; review activities, such as provider education or pre-payment reviews. That is, medical documentation is not required for a single value over 36 percent. However, FIs and carriers must make a determination upon post payment review if the treating physician argues it is medically necessary to have a target hematocrit that is greater than 36 percent (which would then exceed the rolling average of 37.5 percent). These hematocrit requirements apply only to EPO furnished as an ESRD benefit under §1881(b) of the Social Security Act (the Act). EPO furnished incident to a physician's service is not included in this policy. Carriers have discretion for local policy for EPO furnished as "incident to service."

60.4.3 - Payment Amount for Epoetin Alfa (EPO)

(Rev. 719, Issued: 10-21-05, Effective: 01-01-06 BRs 4103.1 and 4103.2, 01-01-04 BRs 4103.3 and 4103.5x, 04-01-06 BRs 4103.4x and 4103.6x, Implementation: 04-03-06)

For Method I patients, the FI pays the facility $10 per 1,000 units of EPO administered, rounded to the nearest 100 units (i.e., $1.00 per 100 units). *Effective January 1, 2005, EPO will be paid based on the ASP Pricing File. Also* effective January 1, 2005, the cost of supplies to administer EPO may be billed to the FI. HCPCS A4657 and Revenue Code 270 should be used to capture the charges for syringes used in the administration of EPO. Where EPO is furnished by a supplier that is not a facility, the DMERC pays at the same rate.

Prior to January 1, 1994, the Method I payment was $11 per 1,000 units.- The statutory payment allowance for EPO is the only allowance for the drug and its administration. Effective January 1, 2005, the cost of supplies to administer EPO may be billed to the FI. HCPCS A4657 and Revenue Code 270 should be used to capture the charges for syringes used in the administration of EPO.

Physician payment is calculated through the drug payment methodology described in Chapter 17 of the Claims Processing Manual.

The composite rate add-on amount (the current $10 per 1,000 unit rate and the past $11 per 1,000 unit rate) is updated nationally by CMS. Effective January 1, 2005, EPO will be paid based on the ASP Pricing File. This add-on does not vary geographically and is the same for hospital-based and independent dialysis facilities.

EXAMPLE: The billing period is 2/1/94 - 2/28/94.

The facility provides the following:

Date	Units	Date	Units

Date	Units	Date	Units
2/1	3000	2/15	2500
2/4	3000	2/18	2500
2/6	3000	2/20	2560
2/8	3000	2/22	2500
2/11	2500	2/25	2000
2/13	2500	2/27	2000

Total 31,060 units

For value code 68, the facility enters 31,060. The 31,100 are used to determine the rate payable. This is 31,060 rounded to the nearest 100 units. The amount payable is 31.1 x $10 =$311.00. In their systems, FIs have the option of setting up payment of $1.00 per 100 units. Effective January 1, 2005, EPO will be paid based on the ASP Pricing File.

EXAMPLE: 311 x $1.00 = $311.00

If an ESRD beneficiary requires 10,000 units or more of EPO per administration, special documentation must accompany the claim. It must consist of a narrative report that addresses the following:

- Iron deficiency. Most patients need supplemental iron therapy while being treated, even if they do not start out iron deficient;
- Concomitant conditions such as infection, inflammation, or malignancy. These conditions must be addressed to assure that EPO has maximum effect;
- Unrecognized blood loss. Patients with kidney disease and anemia may easily have chronic blood loss (usually gastrointestinal) as a major cause of anemia. In those circumstances, EPO is limited in effectiveness;
- Concomitant hemolysis, bone morrow dysplasia, or refractory anemia for a reason other than renal disease, e.g., aluminum toxicity;
- Folic acid or vitamin B12 deficiencies;
- Circumstances in which the bone morrow is replaced with other tissue, e.g., malignancy or osteitis fibrosa cystica; and

Patient's weight, the current dose required, a historical record of the amount that has been given, and the hematocrit response to date.

60.4.3.1 - Payment for Epoetin Alfa (EPO) in Other Settings

(Rev. 719, Issued: 10-21-05, Effective: 01-01-06 BRs 4103.1 and 4103.2, 01-01-04 BRs 4103.3 and 4103.5x, 04-01-06 BRs 4103.4x and 4103.6x, Implementation: 04-03-06)

In the hospital inpatient setting, payment *under Part A* is included in the DRG.

In the hospital inpatient setting, payment under Part B is made on bill type 12x when billed with revenue code 0636 and HCPCS code Q4055. The total number of units as a multiple of 1000 units is placed in the unit field. Effective April 1, 2006, report EPO under the respective revenue code 0634 for EPO less than 10,000 units and revenue code 0635 for EPO over 10,000 units with HCPCS code Q4055. The total number of units as a multiple of 1000 units is placed in the unit field. Payment will be based on the ASP Pricing File.

In a skilled nursing facility (SNF), payment for EPO covered under the Part B EPO benefit is not included in the prospective payment rate for the resident's Medicare-covered SNF stay.

In a hospice, payment is included in the hospice per diem rate.

For a service furnished by a physician or incident to a physician's service, payment is made to the physician by the carrier in accordance with the rules for 'incident to" services. When EPO is administered in the renal facility, the service is not an "incident to" service and not under the "incident to" provision.

60.4.3.2 - Epoetin Alfa (EPO) Provided in the Hospital Outpatient Departments

(Rev. 719, Issued: 10-21-05, Effective: 01-01-06 BRs 4103.1 and 4103.2, 01-01-04 BRs 4103.3 and 4103.5x, 04-01-06 BRs 4103.4x and 4103.6x, Implementation: 04-03-06)

When ESRD patients come to the hospital for a medical emergency their dialysis related anemia may also require treatment. For patients with ESRD who are on a regular course of dialysis, EPO administered in a hospital outpatient department is paid using the statutory rate for EPO given to an ESRD beneficiary. Effective January 1, 2005, EPO will be paid based on the ASP Pricing File.

Hospitals use type of bill 13X and report charges under the respective revenue code 0634 for EPO less than 10,000 units and revenue code 0635 for EPO over 10,000 units with HCPCS code Q4055. The total number of units as a multiple of 1000 units is placed in the unit field. Value code 49 will contain the hematocrit value for the hospital outpatient visit. *Effective for claims dates of service on or after January 1, 2006, hospitals are no longer required to report the value code 49 on the 13x and 85x bill types.*

60.7.3.1 - Payment for Darbepoetin Alfa (Aranesp) in Other Settings

(Rev. 719, Issued: 10-21-05, Effective: 01-01-06 BRs 4103.1 and 4103.2, 01-01-04 BRs 4103.3 and 4103.5x, 04-01-06 BRs 4103.4x and 4103.6x, Implementation: 04-03-06)

In the hospital inpatient setting, *payment under Part A* for Aranesp is included in the DRG.

In the hospital inpatient setting, payment under Part B is made on bill type 12x when billed with revenue code 0636 and HCPCS code Q4054. The total number of units as a multiple of 1mcg is placed in the unit field. *Reimbursement is based on the payment allowance limit for Medicare Part B drugs as found in the ASP pricing file.*

In a skilled nursing facility (SNF), payment for Aranesp covered under the Part B EPO benefit is not included in the prospective payment rate for the resident's Medicare-covered SNF stay.

In a hospice, payment is included in the hospice per diem rate.

For a service furnished by a physician or incident to a physician's service, payment is made to the physician by the carrier in accordance with the rules for 'incident to" services. When Aranesp is administered in the renal facility, the service is not an "incident to" service and not under the "incident to" provision.

60.7.3.2 - Payment for Darbepoetin Alfa (Aranesp) in the Hospital Outpatient Department

(Rev. 719, Issued: 10-21-05, Effective: 01-01-06 BRs 4103.1 and 4103.2, 01-01-04 BRs 4103.3 and 4103.5x, 04-01-06 BRs 4103.4x and 4103.6x, Implementation: 04-03-06)

When ESRD patients come to the hospital for a medical emergency their dialysis related anemia may also require treatment. For patients with ESRD who are on a regular course of dialysis, Aranesp administered in a hospital outpatient department is paid the MMA Drug Pricing File rate. Effective January 1, 2005, Aranesp will be paid based on the ASP Pricing File.

Hospitals use bill type 13X and report charges under revenue code 0636, with HCPCS code Q4054. The total number of units as a multiple of 1mcg is placed in the unit field. Value code 49 will contain the hematocrit value for the hospital outpatient visit. *Effective for claims dates of service on or after January 1, 2006, hospitals are no longer required to report the value code 49 on the 13x and 85x bill types.*

In this case, the DMERC makes payment at the same rate that applies to facilities. Program payment may not be made for Aranesp furnished by a physician to a patient for self-administration.

Medicare Claims Processing Manual

Chapter 17 - Drugs and Biologicals

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(Rev. 719, 10-21-05)

80.9 - Hospitals Billing for Epoetin Alfa (EPO) for Non-ESRD Patients

(Rev. 719, Issued: 10-21-05, Effective: 01-01-06 BRs 4103.1 and 4103.2, 01-01-04 BRs 4103.3 and 4103.5x, 04-01-06 BRs 4103.4x and 4103.6x, Implementation: 04-03-06)

Note: For EPO billing instructions for beneficiaries with ESRD, see the Claims Processing Manual, Chapter 8.

For patients with chronic renal failure who are not yet on a regular course of dialysis, EPO administered in a hospital and billed as an outpatient service on type of bill 13x or inpatient Part B bill type 12x are paid under the Outpatient Prospective Payment System (OPPS). Non-OPPS hospitals are paid on reasonable charges.

Hospitals report charges under revenue code 0636 with HCPCS code Q0136. Value codes 48, 49, and 68 and condition codes 70 through 76 should not be used when billing for EPO administered to non-ESRD patients.

80.10 Hospitals Billing for Darbepoetin Alfa (Aranesp) for Non-ESRD Patients

(Rev. 719, Issued: 10-21-05, Effective: 01-01-06 BRs 4103.1 and 4103.2, 01-01-04 BRs 4103.3 and 4103.5x, 04-01-06 BRs 4103.4x and 4103.6x, Implementation: 04-03-06)

Note: For Aranesp billing instructions for beneficiaries with ESRD, see the Claims Processing Manual, Chapter 8.

For patients with chronic renal failure who are not yet on a regular course of dialysis, Aranesp administered in a hospital and billed as an outpatient service on type of bill 13x or inpatient Part B bill type 12x are paid under the Outpatient Prospective Payment System (OPPS). Non-OPPS hospitals are paid on reasonable charges.

Hospitals report charges under revenue code 0636 with HCPCS code Q0137. Value codes 48, 49 and 68 and condition codes 70 through 76 should not be used when billing for EPO administered to non-ESRD patients.